

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14819

State File No.

FILED MAY 2 1944  
Registration District No. 136

Primary Registration District No. 5572

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural Prairie  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jackson County E. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 22 days (Specify whether years, months or days) 31 yrs.

3. (a) PRINT FULL NAME Lillie Dora Drane

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 29 1873  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70 4 1 hr. min.

9. Birthplace Carthage Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business

12. Name unknown  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Thomas E. Drane (Son)  
(b) Address Independence Mo  
17. (a) Re-moved (b) Date thereof April 2, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Nevada Missouri  
18. (a) Signature of funeral director George C. Carson  
(b) Address Independence Mo  
19. (a) April 1, 1944 (b) F. M. Schuchman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town 11211 Winner Rd  
(If outside city or town limits, write "RURAL")  
(d) Street No. Independence (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30  
year 1944 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from March 8th 1944 to March 30 1944  
that I last saw him alive on 3-30-44 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocardial Disease Duration 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Address \_\_\_\_\_ Date signed 4/2/44

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed George C. Carson

Licensed Embalmer No. 2249

P. O. Address Independence, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**